Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

KULM MEDICAL PA
PO BOX 430
ROWLETT TX 75030

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number:
M4-11-2071-01

MDR Date Received:
February 25, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "This charge was denied for 'unnecessary medical treatment based on peer review.' Please note patient was seen by a designated doctor on 3/11/2010 and the doctor put him on statutory MMI as of 1/25/2010. However, he determined the patient had not reached clinical MMI. Per Rule 126.7(d) the report of the designated doctor is given presumptive weight regarding the issue(s) in question and/or dispute, unless the preponderance of the evidence is to the contrary. Further, this specific cpt code was specifically preauthorized. See attached preauthorization # 987941. Per Rule 134.600c(1)(B), 'the carrier is responsible for all reasonable and necessary medical costs relating to the healthcare… that was approved prior to providing the health care'.

Amount in Dispute: $459.77

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please be advised that the Carrier is currently processing the dates of service in dispute for payment in accordance with the fee guidelines. Once payment is completed, a copy of the payment screens will be forwarded. The Carrie requests that the Requestor withdraw this dispute once payment is received. The Carrier also requests that Medical Fee Dispute Resolution take no further action on this case."

Response Submitted by: Downs-Stanford, PC, 2001 Bryan St., Ste. 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2010, March 8, 2010, March 12, 2010, March 17, 2010, March 29, 2010	CPT Code 97113 (15 Units Total) ($54.32/$36.8729) x $36.71 = $54.08 x 15 units = 811.20 - $407.82 (carrier payment)	$403.38	403.38
March 8, 2010	CPT Code 97140-59-GP (1 Unit) ($54.32/$36.8729) x $27.48 = $40.48 x 1 unit = $40.48 - $27.30 (carrier payment)	$13.18	$13.18
March 29, 2010	CPT Code 97110 (1 Unit) ($54.32/$36.8729) x $29.33 = $43.21 x 1 unit = $43.21	$43.21	$43.21
		Total:	$459.77

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, service and programs provided between February 26, 2010 and March 29, 2010.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated March 12, 2010, March 22, 2010, March 26, 2010, March 30, 2010, April 13, 2010, January 3, 2012:

- W9 – Unnecessary med treatment based on peer review. Payment withheld as peer review indicates documentation does not support the treatment to be medically reasonable and/or necessary.
- Treatment plan has expired.
- W9 – Unnecessary med treatment based on peer review. Peer review obtained by the carrier ind treatment to be medical unreasonable and/or unnecessary and documented srvc does not meet fee guide contained w/I appli AMA CPT/HCPCS guide.
- 50 – These are non-covered services because this is not deemed a medical necessity by the payer. Payment withheld as a required medical exam indicates that medical treatment is not reasonable or necessary.
- 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- W1 – Workers Compensation State Fee Schedule adjustment.
- 18 – Duplicate claim/service.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Did the requestor submit documentation to support that the services were preauthorized in accordance with 28 Texas Administrative Code §134.600 and did the requestor have a contract with First Health?
3. Is the requestor entitled to reimbursement in accordance with 28 Texas Administrative Code §134.203?

Findings

Review of the documentation contained in the request for medical fee dispute resolution finds the requestor submitted their request pursuant to 28 Texas Administrative Code §133.307; therefore, the requestor has met the requirements of the rule.

The respondent initially denied the services as "W9 - unnecessary med treatment based on a peer review," "Treatment plan has expired."; "W9 - Unnecessary med treatment based on peer review. Peer review obtained by the carrier ind treatment to be medical unreasonable and/or unnecessary and documented srvc does not meet fee guide contained w/I appli AMA CPT/HCPCS guide."; and "50 - These are non-covered services because this is not deemed a medical necessity by the payer. Payment withheld as a required medical exam indicates that medical treatment is not reasonable or necessary." The requestor filed a dispute with Medical Fee Dispute Resolution and included a copy of the preauthorization approvel; therefore, the denial, made by the respondent, of unnecessary medical treatment based on a peer review is not supported. The respondent re-audited the dispute dates of service and paid per a PPO contract with First Health. In speaking with the requestor's contact person, the treating doctor, Christopher Blair, D.C. does not have a contract with First Health. No documentation was found to support that such an agreement existed between the parties in dispute, for the dates of service in dispute. For that reason, the Division concludes that these reasons are unsupported. Consequently, the services in dispute will be reviewed per applicable Division rules and fee guidelines.

Pursuant to 28 Texas Administrative Code §134.203(c)(1) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $54.32. Review of the documentation supports additional reimbursement is due to the requestor.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $459.77.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $459.77 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 2, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.